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Chapter 14: Insurance

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C H A P T E R 1 4

Insurance

J. ALBERT BURGOYNE *and* EUGENE LYNE

A. COURT DECISIONS

§14.1. **Fire insurance: Limit of liability.** *Agoos Leather Cos. v. American and Foreign Insurance Co.*¹ involved the very difficult problem of fixing the actual cash value of vacant property destroyed by fire, which at the time of the fire was no longer being used for the purposes for which it was built and was in the process of being dismantled. The defendant insurers appealed a denial of the Superior Court to direct a verdict against the plaintiffs for failure to sustain the burden of proving the amount of their loss. The property, insured under standard Massachusetts fire insurance policies,² was a series of connected buildings that had been used as a tanning plant. During a period of three months following cessation of operation of the plant as a tannery, the machinery and equipment had been sold and were being removed; piping, including the sprinkler system, was being broken up; and the buildings were posted with a "for sale" sign. There was evidence that a sale of the vacant buildings was highly unlikely. The defendants unsuccessfully offered in evidence an agreement for demolition of the buildings, which was excluded for failure to show that the agreement was binding on the owner or owners of the property.

Under the doctrine of *Kingsley v. Spofford*³ the actual value of property insured under the standard fire insurance policy is to be determined in light of the nature of that policy as a contract of indemnity. Recovery is not limited to market value, because in some cases there is none, properly speaking, and in others it would not afford full indemnity. Neither is replacement cost less depreciation conclusive. Either can be important evidence of actual value to be considered together with all other available evidence. Moreover, the

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§14.1. ¹ 1961 Mass. Adv. Sh. 853, 174 N.E.2d 652.

² G.L., c. 175, §99. See also *id.* §96.

³ 298 Mass. 469, 11 N.E.2d 487 (1937).

fact that there is an element of uncertainty in the assessment of damages or that they are difficult of ascertainment is not a bar to recovery. In this case there was a notable lack of probative evidence offered by the parties on the question of value, with the plaintiff's case resting essentially upon an estimate of value by a corporate officer of the plaintiff who had spent forty years in the tanning business and had general superintendence of repairs, replacement, and construction of buildings and productive equipment. The Supreme Judicial Court felt this evidence not so meager as to justify withholding the case from the jury.

§14.2. Accident and sickness insurance: Misrepresentation in application. *Kaufman v. National Casualty Co.*¹ was an action of contract to recover sickness disability benefits under an accident and sickness insurance policy issued on April 2, 1952, to the plaintiff as a member of the Massachusetts Bar Association, and modified upon the payment of an additional premium by an amendment rider made effective April 2, 1958, which had the effect of extending from twelve to twenty-four months the maximum period for which such benefits may be payable under the policy. The plaintiff testified that he was requested to and did sign an application in blank for the amendment rider, that the agent did not go over the questions on the application with him, and that the amendment rider was issued and became attached to the policy on April 2, 1958. On April 1, 1958, the insured apparently suffered a heart attack, which he claimed resulted in his permanent disability, and for which the insurer paid the policy benefits to September 30, 1958. The plaintiff's suit for benefits beyond that date was tried without a jury in the Superior Court, and the trial judge found that the plaintiff (1) did not make the representations in the application and that the application had been signed by him in blank, (2) was wholly and continuously disabled, and (3) did not violate the policy provision requiring him to submit to medical examination.

In overruling exceptions to the judge's denial of requests for rulings, the Supreme Judicial Court held that recovery under the policy rider was not conditioned upon the absence of any disease of the heart or any bodily injury prior to the date of issuance of the rider, since the insured did not and was not required to make any representations with respect to the state of his health when he accepted the agent's offer to extend coverage theretofore provided by the policy. Presumably this aspect of the dispute is relevant only to the benefits provided by the extension rider. Even if it is assumed that the plaintiff did complete the application and that it could be found that he suffered a coronary attack prior to the date of the rider and that he gave no notice to the insurer of the consequent change in his physical condition, the judge is not required as a matter of law to find that the plaintiff actually intended to deceive the insurer or that the risk of loss to the insurer was necessarily increased. Unless the misrepresentation is made

§14.2. 1 342 Mass. 412, 174 N.E.2d 35 (1961).

with actual intent to deceive or unless the matter misrepresented increased the risk of loss, it will not defeat the policy.²

§14.3. Motor vehicle insurance: Compulsory coverage. In *Culkin v. Cosman*¹ the plaintiff sought to reach and apply the respective obligations of the Great American Indemnity Company under a Massachusetts garage liability policy and the Aetna Casualty and Surety Company under a Massachusetts motor vehicle policy to the satisfaction of a judgment obtained by the plaintiff against Cosman. Cosman, who appears as a party in this action only by a written assent to the statement of agreed facts, was employed by the garage company insured by Great American. The plaintiff's injury was sustained as a consequence of being struck on a public way by an automobile, owned by a storage customer of the garage and insured by Aetna, while it was being delivered by Cosman to the owner's residence. At the time of the accident the automobile bore only the registration plates of the owner. The Supreme Judicial Court rejected the argument of Great American that its policy did not cover the storage branch of its insured's business, pointing out that the statutory bodily injury liability coverage is not conditioned upon any specified use of automobiles. Moreover, the automobile driven by its employee was within the control of the garage company and under its blanket registration as a dealer, although at the time of the accident the dealer's plates were not actually attached to it.²

Aetna contended that it should not be liable on the judgment, arguing that if it paid under the statutory bodily injury liability coverage of its policy, it would be entitled to reimbursement from Cosman under the provisions of the policy giving it a right of reimbursement for any payment made under the statutory coverage which it would not have been obligated to make if the terms of the policy applicable to the non-statutory portions of the coverage also applied to the statutory coverage. Since it is intended that the coverage for garage operations be afforded under the garage liability policy, the insurance for persons, other than the named insured, under the nonstatutory portions of the owner's policy does not cover the garage company or its employee with respect to any accident arising out of the operation of the garage. But the Court refused to accede to Aetna's request that it adjudge the ultimate liability of the parties inasmuch as the question of Cosman's contingent liability to Aetna was not adequately presented and a resolution of that question was not necessary to a determination of the rights of the judgment creditor. Both insurers, therefore, were found to be obligated on the judgment, but the plaintiff is entitled to but one satisfaction.

§14.4. Policy conditions: Assistance and cooperation. *Jertson v.*

² G.L., c. 175, §186. See also *Lennon v. John Hancock Mutual Life Insurance Co.*, 339 Mass. 37, 157 N.E.2d 518 (1959), discussed in 1959 Ann. Surv. Mass. Law §16.3.

¹ 1961 Mass. Adv. Sh. 1133, 175 N.E.2d 493.

² *Maryland Casualty Co. v. Hunter*, 341 Mass. 238, 168 N.E.2d 271 (1960), discussed in 1960 Ann. Surv. Mass. Law §16.6.

*Hartley*¹ was a suit in equity to reach and apply the property damage liability provisions of a motor vehicle liability policy, issued by the defendant Lumbermens Mutual Casualty Company, in satisfaction of a judgment entered against the defendant Hartley for damage to an automobile owned by the plaintiff. The plaintiff's automobile was damaged as a consequence of a collision with an automobile driven by Hartley, but registered in the name of Hartley's mother. Prior to the tort action, conflicting statements were made by Hartley and his mother as to whether the son had purchased the automobile as agent of his mother and was driving with her consent or had purchased the automobile with his own money and had it registered in his mother's name only because he was a minor. In defense of this suit the insurer set up the named insured's lack of insurable interest in the automobile and noncooperation in the defense of the tort action. The Supreme Judicial Court held that the first of these defenses could not be sustained and that the trial court's finding in the tort action that the automobile was properly registered in the mother's name was admissible in the equity action, since such finding was material on the issue of ownership of the automobile. With respect to the second defense, it is clear that the intentional furnishing of false information of a material nature either before or at trial is a breach of the cooperation clause.² But in the view of the Court it could be found that the alleged false statements pertaining to the ownership of the automobile and the title to the money with which it was purchased were not made with an intention to deceive but resulted from the ignorance of Hartley and his mother of what might be the legal consequences of their acts.

§14.5. **Policy conditions: Changes.** *Benoit v. Fisher*¹ was an action to reach and apply the obligation of the General Accident Fire and Life Assurance Corporation under the property damage liability coverage of a Massachusetts motor vehicle policy effective January 1, 1958, issued by it to Fisher. Late in March, 1958, the agent through whom the insurance was placed sought to collect the policy premium, found the insured unable to pay it, and reached agreement with the insured to modify the policy as of its effective date by reducing the bodily injury liability coverage to the statutory limits of liability (\$5000 each person and \$10,000 each accident) and eliminating the property damage liability coverage. While some notice was apparently given to the insurer, no endorsement reflecting this modification had been issued to form a part of the policy on May 6, 1958, the date of the collision causing injury to the plaintiff's automobile. The Supreme Judicial Court held that the policy as it read on the day of the accident was prima facie evidence of coverage and the insurer had the burden of proof that coverage had been eliminated after issuance of the policy and before the occurrence of the accident. Failing to produce evidence that the

§14.4. 1 1961 Mass. Adv. Sh. 847, 174 N.E.2d 663.

² Cassidy v. Liberty Mutual Insurance Co., 338 Mass. 139, 154 N.E.2d 353 (1958), discussed in 1959 Ann. Surv. Mass. Law §16.6.

§14.5. 1 341 Mass. 386, 169 N.E.2d 905 (1960).

agent had actual or apparent authority to cancel or modify the policy, the insurer failed to sustain that burden.

§14.6. Equitable estoppel of insurer to deny coverage: Insurer's failure to verify. In *Clauson v. Prudential Insurance Co. of America*,¹ the defendant insurer issued to Chrysler Motors Corporation a group policy by which term life insurance was made available to owners of Chrysler dealerships. The amount of insurance available to a dealer depended upon the number and type of Chrysler motor vehicles shipped to the dealership during the preceding calendar year. The insurance program was voluntary and required partial payment of premiums by the dealers who enrolled.

The insured was urged to subscribe for \$30,000 of insurance, the maximum amount to which Chrysler's preliminary records indicated he was entitled. He stated that his records of shipments indicated that he was entitled to \$50,000 of coverage and that he would not be interested in any lesser amount. It was agreed, since Chrysler's records might be wrong, to go forward on the assumption that \$50,000 was the correct figure subject to verification by Chrysler. In actual fact, \$30,000 was the correct figure. However, Chrysler never verified its figures and the defendant therefore issued to the insured a certificate in the amount of \$50,000. The present litigation arose on the question of whether the insured's beneficiary was entitled to the additional \$20,000 of life insurance after the death of the insured.

The Supreme Judicial Court found for the beneficiary on the ground of equitable estoppel, pointing out that there was no evidence of fraud on the part of the dealer-insured in originally claiming that he was entitled to \$50,000 of coverage, that he had stated that he had no interest in the program unless such coverage was available, and that he had reasonably relied upon the assumption that Chrysler would verify its records and speedily inform him if \$30,000 was in fact the maximum amount to which he was entitled. The opinion infers that the dealer-insured might have made other arrangements for insurance coverage had he been so informed, stating that in "any aleatory contract, a party who has failed to make a timely assertion of his rights may be foreclosed from taking advantage of them after a lapse of time during which the risk has been determined."

The decision appears to be sound, particularly in light of the unusual complexity of the formula for determination of the amount of coverage to which any particular dealer was entitled. The insurer's contention that estoppel cannot be invoked to extend the coverage of a policy to a risk not within its terms, under *Palumbo v. Metropolitan Life Insurance Co.*,² is distinguishable because in the *Palumbo* case the risk had been determined prior to the alleged act of estoppel.

§14.7. Equitable estoppel of insurer to deny coverage: Medical examiner as agent. *Sullivan v. John Hancock Mutual Life Insurance*

§14.6. ¹ 195 F. Supp. 72 (D. Mass. 1961).

² 293 Mass. 35, 199 N.E. 335 (1935).

*Co.*¹ is a disturbing case, as the opinion disregards or distinguishes a long-standing line of cases for reasons that appear to be unsound.

The chronology of undisputed facts included the following: on February 20, 1957, the insured first complained of severe headaches; on February 21 and again on March 5, he consulted and was treated by his doctor; on March 10, he was hospitalized and was the subject of X rays, electrocardiograms, and blood studies; on March 15, he was discharged from the hospital; on March 18, he applied for a life insurance policy; on March 24, he was examined and questioned by the insurance company examining physician; on April 10, the policy issued; and on May 8, the insured died of a cerebral aneurysm.

The application on the basis of which the policy was issued included questions asking the insured (1) whether he had ever had or been treated for severe headaches; (2) whether he had ever had any X rays or electrocardiograms or blood studies; (3) whether he had consulted a doctor within the preceding five years; (4) whether he had been hospitalized within the preceding five years. The recorded answer to each of these questions was negative, and the insurer defended the suit on the ground that the application contained misrepresentations which were made with intent to deceive, or which increased the risk of loss.²

The beneficiary of the policy conceded that the recorded answers were in fact misrepresentations but testified that the insured had in fact given truthful answers to all the questions asked by the examining physician and had then signed the application in blank. The jury found for the plaintiff, and the case was considered by the Supreme Judicial Court on the basis that the examining physician (for some reason unknown) had failed to record correctly the answers given by the applicant for insurance.

After a lengthy discussion of the equities of the case, the Court held that the examining physician was the defendant's agent and that the defendant must therefore suffer the consequence of his action. The only cited authority for this crucial determination is *Giannelli v. Metropolitan Life Insurance Co.*,³ in which an examining physician was held to be an agent of the defendant company for purposes of the interrogatory statute. The Court wholly ignores the specific provisions of both the application and the policy to the effect that neither an agent nor an examining physician can either make a contract or waive any of the policy provisions. It disregards *Schiller v. Metropolitan Life Insurance Co.*,⁴ in which it specifically held that the company was not bound by the actions of an examining physician who altered the answers given by an applicant for insurance, although in the *Schiller* case there were no express limitations upon the authority of the examining physician.

§14.7. 1 1961 Mass. Adv. Sh. 907, 174 N.E.2d 771.

² G.L., c. 175, §186.

³ 307 Mass. 18, 21, 29 N.E.2d 124, 126 (1940).

⁴ 295 Mass. 169, 175, 3 N.E.2d 384, 387 (1936).

The Court does undertake to distinguish the line of cases typified by *Bogosian v. New York Life Insurance Co.*⁵ on the ground that such cases "involve applications for reinstatement of lapsed policies and other conditions such as proof of loss in which truthful answers are a condition precedent to recovery"⁶ by pointing out that the *Sullivan* case involved a representation rather than a condition precedent. Having made this distinction, the Court concluded that on general principles of equity and estoppel, "[i]t would be unfair to permit an insurance company to avoid a contract of insurance because of the failure of the company's own . . . examining physician correctly to record the answers given by an applicant."⁷ The Court does not touch upon the actual principal holding of the *Bogosian* case to the effect that the applicant is presumed to have known the provisions of the policy limiting the agent's authority and therefore has the duty to see to it that a proper application is filed. To the same effect, *Kukuruza v. John Hancock Mutual Life Insurance Co.*⁸ held that if the certificate of insurability was not signed by the insured, there was no contract between the parties.

It is therefore difficult to reconcile the *Sullivan* case with a long line of Massachusetts authorities, and it may be significant to note that the Court carefully refrained from overruling any of the prior cases. Rather the Court appears to have reached its decision on equity and estoppel grounds and then steered a rather careful course around the precedents which lay in its way. This represents a rather unusual departure from the past practice of the Court, which traditionally has left such problems to the legislature.

The writer submits, however, that the decision is unsound even when considered from the point of view of equity and estoppel. In this connection it is of interest to compare the facts in the *Sullivan* case with those in the *Clauson* case.⁹ In the *Clauson* case, the federal court pointed out that the records determinative of the amount of coverage actually available were in the hands of Chrysler, and that neither Chrysler nor the insurer checked these records until the insured had died. It therefore held that the insurer was estopped to deny that the insured was entitled to the full \$50,000 coverage for which a certificate had been issued. In the *Sullivan* case the insured issued a policy based upon the application filed on behalf of the insured. A Massachusetts statute requires the annexation to the policy of a correct copy of the application.¹⁰ The purpose of this statute, as stated in *Schiller v. Metropolitan Life Insurance Co.*, "is to furnish every person holding insurance upon his life a copy of the application, upon which the effectiveness of the policy may in some circumstances depend, so that he

⁵ 315 Mass. 375, 53 N.E.2d 217 (1944).

⁶ 1961 Mass. Adv. Sh. 907, 910, 174 N.E.2d 771, 773.

⁷ 1961 Mass. Adv. Sh. at 911, 174 N.E.2d at 774.

⁸ 276 Mass. 146, 150, 176 N.E. 788, 790 (1931).

⁹ 195 F. Supp. 72 (D. Mass. 1961), noted in §14.6 *supra*.

¹⁰ G.L., c. 175, §131.

may know the exact terms of the contract.”¹¹ In the *Sullivan* case the policy was delivered to the insured three days prior to his final illness and nineteen days prior to his death. During this period he had every opportunity to examine the photostatic copy of the application which was “annexed to and made a part of” the policy and to ascertain the fact that his answers to the pertinent medical questions had been incorrectly recorded. Instead no action was taken until after his death, until the risk had been determined. This fact situation is indistinguishable in principle from that existing in the *Clauson* case, and the representatives of the insured should be estopped from claiming that the insured’s answers were incorrectly recorded.

It should be noted that there is nothing in the record to support an allegation that the insurer had any knowledge of the rather incomprehensible action of its examining physician in allegedly recording false answers to six questions on the application. As the Court said in the *Schiller* case, the insurer “had every ground to believe that the application on file with it was genuine. The legislative intent was to impose upon the insurer an obligation capable of being met and not one impossible of performance.”¹² The *Sullivan* decision, by way of contrast, effectively places upon the life insurance companies the almost impossible task of carefully investigating the medical history of each applicant to verify the answers recorded in the application. This decision should not be followed.

Another point remains to be made in connection with this case. The Court holds that its decision does not prejudice the insurer because the latter may still demonstrate that the insured supplied untruthful answers with intent to deceive or such that the risk of loss was increased. With reference to the former, any jury that accepts testimony to the effect that the applicant gave true answers which were then falsely recorded by an agent of the insured simply cannot find a misrepresentation with intent to deceive. With reference to increased risk of loss, the Court sustained the trial judge in denying the defendant’s request for an instruction allowing the jury to find that the insured had a cerebral aneurysm at the time of making application, and that this condition operated to increase the risk of loss. It notes that there was no question in the application directly relating to cerebral aneurysms and states that “therefore there could be no misrepresentation on this point.”¹³ If this is a correct statement of Massachusetts law, it would appear that the insurance companies, in order to be sure of retaining the defense of increased risk of loss under the statute, must include in their applications specific questions relating to each and every disease known to medical science. This is patently impossible. It would also appear to be legally unavailing in that questions on disease entities call only for an expression of opinion and cannot involve a misrepresenta-

¹¹ 295 Mass. 169, 173, 3 N.E.2d 384, 386 (1936).

¹² 295 Mass. at 175, 3 N.E.2d at 387. Certainly no reasonable person could think that the insurer would have issued a policy had it received an application containing the answers allegedly given by the insured.

¹³ 1961 Mass. Adv. Sh. 907, 914, 174 N.E.2d 771, 776.

tion as such.¹⁴ An applicant should certainly know whether he has had severe headaches requiring medical attention; he will almost never know whether they are caused by a cerebral aneurysm. Hence a question directed specifically to that specific disease entity would be wholly useless. Yet a cerebral aneurysm can (and, in the probably unanimous opinion of medical men, does) increase the risk of loss in that it has a tendency to shorten life. The statement in the opinion appears to be dictum, since the requested instructions could probably have been refused on the ground that it requested a ruling that a cerebral aneurysm increased the risk as a matter of law. This proposition, although arguable as a matter of fact, is not Massachusetts law at present.

B. LEGISLATION

§14.8. Fire insurance. In certain areas within the city of Boston a substantial proportion of dwelling house properties have become marginal in character, a significant number are dangerous to life and property because they do not conform to municipal ordinances designed to protect the public health and safety, and a relatively small number are totally uninsurable. Under these circumstances insurers find it necessary to guard against overcommitments in these areas on properties insured at manual rates. It is apparent that making coverage freely available on many of these properties would seriously aggravate the already serious problems besetting fire prevention and fire fighting activities in these areas.

During the 1961 legislative session, responding to complaints that dwelling fire insurance could not be obtained or, more accurately, could not be obtained at manual rates in admitted companies,¹ the General Court gave serious consideration to the enactment of legislation that would create an assigned risk plan as a device to make such insurance available to persons otherwise unable to obtain it. While it was recognized that this proposal may quite possibly be unconstitutional and that certain properties ought not to be insured, nevertheless a bill was passed in the House of Representatives but failed of enactment in the Senate.

¹⁴ *Metropolitan Life Insurance Co. v. Burno*, 309 Mass. 7, 9, 33 N.E.2d 519, 520 (1941).

§14.8. ¹ General Laws, c. 174A, §6(d), provides: "Upon the written application of the insured, stating his reasons therefor, filed with and approved by the commissioner [of insurance], a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk." General Laws, c. 175, §68, as amended by Acts of 1961, c. 413, noted in §16.16 *infra*, provides: "Whenever [a special broker] shall procure any insurance [in a foreign company not authorized to transact business in the Commonwealth] on any such property or interest, he shall in every case execute and, within five days thereafter, file with the commissioner [of insurance] an affidavit stating that the full amount of insurance required to protect said property or interests is not procurable, after a diligent effort has been made to do so, from among companies admitted to transact insurance in the commonwealth against the hazard or hazards involved, and that the amount of insurance procured in foreign companies not authorized to transact such business in the commonwealth is only the excess over the amount so procurable from such admitted companies."

Failing passage of the assigned risk plan legislation, the Division of Insurance was authorized and directed² to make an investigation and study relative to the difficulty encountered by property owners in securing fire insurance, and relative to a plan of apportionment and service charges to be made when such persons are unable to obtain such insurance. The division was required to report to the clerk of the Senate the results of its investigation and study, its recommendations, if any, and its proposals for legislation necessary to carry out its recommendations on or before the last Wednesday of December, 1961.

Very serious problems underlie this development, problems that will hardly be resolved by compelling insurers to provide insurance to all comers. More rigid enforcement of building, fire prevention, and public health codes is obviously needed. To make insurance available without correction of building faults or maintenance deficiencies serves only to put a premium upon the lack of compliance with municipal health and safety requirements, which in turn contributes to the extra-hazardous character of the areas involved. To insure properties that should be condemned and removed is an invitation to arson. To require insurers to write such substandard properties at a premium rate which is inadequate for the risk assumed imposes an improper burden upon the insurers or upon those insureds who make an effort to maintain their properties properly.

The enactment of assigned risk plan legislation may make it easier for a limited number of property owners to obtain insurance, but cannot be expected to provide a cure for the basic difficulty of widespread property deterioration which must be dealt with in Boston and in all of the aging metropolitan areas of the country.

§14.9. Motor vehicle insurance: Transferred registration. The automobile dealers of the Commonwealth have succeeded in securing the enactment of legislation permitting the transfer of registration plates to a newly acquired motor vehicle. Effective January 1, 1962, Acts of 1961, c. 568,¹ permits a person who transfers to another ownership of a registered motor vehicle and intends to transfer the registration to a newly acquired motor vehicle, to operate the newly acquired motor vehicle from the date of transfer until 5:00 P.M. of the second following Registry of Motor Vehicles business day within the same calendar year, provided the number plates from the transferred motor vehicle are attached to the newly acquired motor vehicle. This act also requires² that every motor vehicle liability policy, issued to become effective on and after January 1, 1962, contain a provision to the effect that it shall continue in force and cover the newly acquired motor vehicle in lieu of the transferred motor vehicle for the same period and subject to the same conditions as specified for the transfer of the registration.

§14.10. Motor vehicle insurance: Leased vehicles. In 1959 the

² Resolves of 1961, c. 114.

§14.9. ¹ Section 1, amending G.L., c. 90, §2.

² Section 2, amending G.L., c. 175, §113A.

legislature imposed¹ on every person engaged in the business of leasing motor vehicles under the "drive it yourself" system the obligation of maintaining after January 1, 1960, a motor vehicle liability policy or bond or deposit covering not only compulsory bodily injury liability protection but also property damage liability protection in the amount of \$1000. Acts of 1961, c. 177,² has modified the compulsory property damage liability insurance requirement to make it inapplicable to motor vehicles so leased for a term of more than thirty days.

§14.11. Motor vehicle insurance: School buses. Under the provisions of Acts of 1961, c. 307,¹ the limit of liability required to be carried on buses, other than common carriers, used for the transportation of school children is increased from \$5000 each person, \$50,000 each accident, to \$15,000 each person, \$200,000 each accident. By Acts of 1961, c. 659, the effective date of the new insurance requirement is postponed to January 1, 1962.

§14.12. Insurance on mortgaged properties. Acts of 1961, c. 533,¹ authorizes provisions in a note or mortgage given to a bank in connection with a real estate loan requiring periodic payments of estimated betterment assessments, taxes, and premiums for fire insurance or mortgage credit insurance. Mortgage credit insurance, however, may be placed only at the request of the mortgagor and if the amount of the mortgage note is not less than 75 percent of the purchase price.

§14.13. Share insurance: Credit unions. Acts of 1961, c. 294, establishes and makes detailed provisions for the operation of the Massachusetts Credit Union Share Insurance Corporation to insure the shares of Massachusetts credit unions in essentially the same manner as the Cooperative Central Bank¹ insures shares in cooperative banks established under the laws of the Commonwealth.

§14.14. Group insurance: Public employees. Acts of 1961, c. 572, amends the provision of the Group Insurance Plan for Employees of the Commonwealth¹ which requires the application of a pro rata share of any dividends or other refunds or rate credits received by the Commonwealth on policies insuring the payment of benefits under the plan to the reimbursement of federal or other funds contributed in place of the Commonwealth's share of the premium cost. The newly revised section establishes a fund to be known as the "group insurance commission trust fund" into which all such premium refunds are to be deposited. It also fixes a formula for the determination of the amount of the premium refund allocable to the net premium paid by the Com-

§14.10. ¹ Acts of 1959, c. 282, amending G.L., c. 90, §§32E, 34A, 34D, 34J, noted in 1959 Ann. Surv. Mass. Law §16.10.

² Amending G.L., c. 90, §§32E, 34A, 34D.

§14.11. ¹ Amending G.L., c. 40, §4.

§14.12. ¹ Adding new §58 to G.L., c. 167.

§14.13. ¹ Established by Acts of 1932, c. 45, as amended by Acts of 1934, c. 73.

§14.14. ¹ G.L., c. 32A, §9, as amended by Acts of 1958, c. 424, noted in 1958 Ann. Surv. Mass. Law §18.13.

monwealth and to the amount contributed by federal or other funds after a pro rata distribution of the total administrative cost of the plan during the period covered by the refund. If the total administrative cost exceeds the Commonwealth's allocable share of the refund, the total refund is credited to the Commonwealth and the excess cost is charged against the federal or other funds available for the purpose. If the refund allocable to federal or other funds exceeds the administrative cost charged to such funds, the excess dividend is paid to the funds. If the Commonwealth's allocable share of the refund exceeds the total administrative cost plus its share of the excess dividend (net premium paid by the Commonwealth to total net premium), the balance of the excess dividend (net premium paid by insured employees to total net premium) is to be invested for the benefit of the insured employees. A new section² creates an investment committee to supervise such investments and authorizes the Group Insurance Commission to expend such funds at its discretion in the best interests of the insured employees.

In 1960 the Group Insurance Plan for Employees of the Commonwealth and the Group Insurance Plan for Employees of Counties, Cities, Towns and Districts³ were amended to permit continuation of the group hospital, surgical, and medical benefits by the surviving spouse of a deceased retired employee until the remarriage or death of the surviving spouse. These plans were further amended by Acts of 1961, cc. 414⁴ and 214,⁵ to permit such continuation of insurance benefits by the surviving spouse of any employee, whether or not retired. Insurance coverage may be continued until the remarriage or death of the surviving spouse, without premium contribution by the Commonwealth of the governmental unit.

The Group Insurance Plan for Employees of Counties, Cities, Towns and Districts was further extended by Acts of 1961, c. 334,⁶ to make available to such employees group life insurance and group accidental death and dismemberment insurance above the \$2000 of coverage required to be provided. The additional amounts of insurance which may be obtained are based upon the employee's gross salary and must be paid for by the employee without any premium contribution by the governmental unit. The optional additional coverage provision⁷ becomes effective for a county, city, town, or district upon adoption by the appropriate vote specified in the statute. The policies of group life insurance covering such employees may also provide not more than \$1000 of group life insurance for retired employees who, up to the effective date of such policies, were insured under a group life policy ob-

² Acts of 1961, c. 572, §2, adding a new §9A to G.L., c. 32A.

³ Acts of 1960, c. 386, adding a new §11 to G.L., c. 32A, and a new §9B to G.L., c. 32B, noted in 1960 Ann. Surv. Mass. Law §16.13.

⁴ Amending G.L., c. 32A, §11.

⁵ Amending G.L., c. 32B, §9B.

⁶ Amending G.L., c. 32B, §§3-5, 9, and adding a new §11A.

⁷ G.L., c. 32B, §11A.

tained by the governmental unit.⁸ An employee who terminates service prior to retirement and whose retirement is deferred is regarded as being on a leave of absence and may continue his full coverages, provided application is made therefor and the full cost is borne by the separated employee.⁹

§14.15. Policy conditions: Appraisal. Late in the 1960 session the General Court enacted into law a requirement that every policy of insurance against physical damage to a motor vehicle contain a prescribed arbitration provision.¹ This legislation was aimed at a small number of companies issuing motor vehicle physical damage policies not containing an arbitration provision to resolve a failure of the insured and the company to agree as to the amount of a loss under the policy. This legislation affected not only these companies but also all other companies, the great majority of which use policies prepared in accordance with the Standard Provisions for Automobile Policies.² Under these circumstances most companies would have been required to endorse every motor vehicle physical damage policy to conform the arbitration provision to the new statutory provision.

Acts of 1961, c. 92, strikes out the original enactment and substitutes a new section³ which requires that every such policy contain in substance the arbitration provision set forth therein. The language of the provision included in the statute is a verbatim recitation of the "Standard Provisions" arbitration condition, thus reaching the non-conforming companies but allowing the other companies to continue the use of a long-established policy provision. This amendment, enacted with an emergency preamble, is made effective February 23, 1961, the date upon which the 1960 enactment would have become effective.

§14.16. Insurance companies. Acts of 1961, c. 168, has established substantially increased financial requirements for companies formed or seeking admission to write liability insurance in Massachusetts.¹ Mu-

⁸ Id. §9, as amended by Acts of 1961, c. 100.

⁹ G.L., c. 32B, §9, as amended by Acts of 1961, c. 334.

§14.15. ¹ Acts of 1960, c. 793, adding new §191A to G.L., c. 175.

² The so-called Standard Provisions Program was first developed for automobile insurance policies in 1934-1935 in response to legislative threats to enact statutory standard automobile policies. Cf. Sawyer, *Automobile Liability Insurance* (1936). The program, which is a vehicle for the voluntary adoption of standardized insurance policy provisions for use nationally by the insurance companies, is currently maintained as respects automobile insurance by the Mutual Insurance Rating Bureau, the National Bureau of Casualty Underwriters, and the National Automobile Underwriters Association. Since 1936 the program has been expanded to encompass general liability, workmen's compensation, burglary, and other forms of policies.

³ G.L., c. 175, §191A.

§14.16. ¹ General Laws, c. 175, §47, specifies the kinds of insurance which may be written by insurance companies. Clause Sixth specifies: (a) accident, (b) legal liability for loss or damage on account of the injury or death of any other person or on account of any damage to property of another, (c) loss or damage to motor vehicles from collision, (d) health, or (e) workmen's compensation. Clause Sixteenth specifies: life insurance and contracts for the payment of annuities and pure endowments.

tual companies formed to transact liability insurance under Clause Sixth of Section 47 must now have a minimum paid-up guaranty capital of \$400,000.² A stock company formed to transact business under Clause Sixth must now have a minimum paid-up capital of \$400,000; to transact business under Clauses 6 and 16 it must have a minimum paid-up capital of \$600,000 and, in addition, a net cash surplus of \$400,000.³ A domestic stock company chartered to write life insurance may also transact business under Clause Sixth of Section 47 if it satisfies the foregoing minimum financial requirements.⁴ A domestic mutual life company may likewise combine with life insurance business under Clause Sixth, excluding workmen's compensation, if it has net cash assets over all liabilities of at least \$800,000.⁵ Any domestic company authorized to write fire and allied lines of insurance, marine insurance, or liability insurance may write all forms of motor vehicle insurance, liability and physical damage, if it maintains a surplus to policyholders including any guaranty capital of not less than \$600,000.⁶ Corresponding increases have been made in the financial requirements which must be satisfied by foreign companies seeking admission to transact business under Clause Sixth of Section 47.⁷ The new requirements do not apply to any company formed or admitted prior to May 31, 1961.

Acts of 1961, c. 413,⁸ modifies the requirements with respect to the affidavit which must be filed with the Commissioner of Insurance by special insurance brokers negotiating contracts of insurance with non-admitted companies. The statute heretofore required the filing by the broker of an affidavit before procuring the unauthorized insurance, stating that he is unable to procure the necessary coverage in admitted carriers and that he will obtain all of the insurance available in the admitted market before he procures any coverage in the non-admitted market. Under the revised statute the special broker is required only to file an affidavit that the full amount of coverage needed is not procurable from admitted companies and that the amount of insurance procured in non-admitted companies is only the excess over the amount procurable from admitted companies. This chapter also amends the statute with respect to agents' and brokers' commissions⁹ to permit the payment of a commission or brokerage fee by a special insurance broker to a regularly licensed insurance broker in connection with insurance negotiated in a non-admitted company.

Acts of 1961, c. 126,¹⁰ amends the requirement of authorization by the board of directors of salary payments to persons other than officers

² G.L., c. 175, §93. References to the statute in this note and notes 3-9 *infra* refer to the statute as amended by Acts of 1961, c. 168.

³ G.L., c. 175, §48.

⁴ Id. §51.

⁵ Id. §54.

⁶ Id. §54C.

⁷ Id. §151.

⁸ Id. §168.

⁹ Id. §177.

¹⁰ Amending G.L., c. 175, §35, as amended by Acts of 1960, c. 63.

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and directors by increasing from \$10,000 to \$20,000 the minimum annual amount requiring such authorization.

Acts of 1961, c. 129,¹¹ authorizes investment by domestic insurance companies in bonds, notes, or obligations issued, assumed, or guaranteed by the Inter-American Development Bank.

¹¹ Amending G.L., c. 175, §63, par. 3A.